POLICY: HEALTH CARE COORDINATION

POLICY STATEMENT: It is the policy of the Bureau of Disability Determination Services (BDDS) that health services necessary to meet the needs of an Individual receiving supported living services shall be coordinated by an identified responsible person or entity.

DETAILED POLICY STATEMENT:

Health Care Coordination Responsible Party

1. The person or Provider responsible for Health Care Coordination for an Individual shall be documented in the Individual's Individualized Support Plan (ISP), and be one of the following:
    a. the Individual when receiving services under Support Services Waiver;
    b. a family member of the Individual or other person selected by the Individual or Legal representative of the Individual when receiving services under Support Services Waiver;
    c. the Residential Habilitation and Support Provider for the Individual, or Individuals, receiving services under Medicaid waiver when receiving services under Autism or Developmental Disability Waiver; or
    d. the Health Care Coordination Provider for Individuals receiving services under State Line Item.

Health Care Coordination Services received by an Individual

1. The party responsible for Health Care Coordination shall coordinate the health care received by the Individual, including but not limited to:
    a. annual or more frequent physical, dental, and vision examinations as ordered by the Individual's physician, and follow-up of any recommendations resulting from these examinations;
    b. routine examinations as ordered by the Individual's physician, and follow-up of any recommendations resulting from these examinations;
    c. routine screenings as ordered by the Individual's physician, and follow-up of any recommendations resulting from these screenings;
    d. identification and treatment of conditions as ordered by the Individual's physician, and follow-up of any recommendations resulting from identification and treatment of these conditions;
    e. referrals to specialists and follow-up of any recommendations resulting from these referrals;

f. routine health care not requiring the intervention of a physician or specialist, and follow-up of any recommendations resulting from this health care;
g. hospice services; and
h. all additional supports.

Documentation of Health Care Coordination received by an Individual

1. The party responsible for Health Care Coordination shall maintain personal information for each Individual served.
2. The Individual's personal information shall include the following information:
    a. The date of health and medical services provided to the Individual.
    b. A description of the health care or medical services provided to the Individual including but not limited to:
        i. orders;
        ii. recommendations; and
        iii. responses to each health or medical service.
    c. The signature of the person providing the health care or medical service for each date a service is provided.
    d. Additional information and documentation required in this rule include documentation of the following:
        i. For Individuals who take medication:
            1. An organized system for medication administration.
            2. An Individual's refusal to take medication.
            3. Monitoring of medication side effects.
            4. Monitoring of medication errors.
            5. Response to medication errors which includes actions initiated to prevent reoccurrence.
        ii. An organized system for:
            1. medical treatments and nursing interventions; and
            2. tasks, treatments, and interventions delegated by a qualified licensed medical professional.
        iii. Seizure tracking for Individuals with seizure disorders.
        iv. Changes in an Individual's status.
        v. An organized system of health-related incident management.
        vi. Risk plans as indicated for the Individual and progress on each risk plan.
        vii. If applicable to this Provider, a review of the death of an Individual.
3. Documentation as described in this section shall be maintained by the Provider in a manner that allows for review at the time a verbal or written request is made by the Family and Social Services Administration (FSSA), the Division of Disability and Rehabilitative Services (DDRS), the Office of Medicaid Planning and Policy (OMPP) or their agents or contractors.

Organized System for Medication Administration, Medical Treatments, Nursing Interventions, and other tasks delegated by a Licensed Medical Professional

1. The party responsible for Health Care Coordination shall ensure an organized system that complies with laws and regulations governing a licensed or accredited person's profession for:
    a. medication administration:
    b. medical treatments;
    c. nursing interventions; and
    d. tasks delegated by a qualified licensed medical professional for the Individual.
2. The Provider shall ensure that the system identified is:
    a. personalized based on the specific needs of the Individual;
    b. documented in writing; and
    c. distributed in writing to all Providers administering:
        i. medication;
        ii. medical treatment;
        iii. nursing intervention; or
        iv. tasks delegated by a qualified licensed medical professional to the Individual.
3. The document shall be placed in the Individual's file maintained by all Providers administering medication and medical treatments to the Individual.
4. The system required in subsection (1) shall contain at minimum the following elements:
    a. Identification and description of each:
        i. medication;
        ii. medical treatment;
        iii. nursing intervention; and/or
        iv. tasks delegated by a qualified licensed medical professional required for the Individual.
    b. Documentation that the Individual's medication is administered only by trained and authorized personnel unless the Individualized Support plan states that the Individual is capable of self-administration of medication.
    c. Documentation of the administration of all medication, including the following:
        i. Administration of medication from original labeled prescription containers.
        ii. Name of medication administered.
        iii. Amount of medication administered.
        iv. The correct route of medication administered.
        v. The date and time of administration.
        vi. The initials of the person administering the medication.
    d. Procedures for the destruction of unused medication.
    e. Documentation of medication administration errors.
    f. Documentation of narcotics and/or scheduled drugs including the:
        i. receipt from the pharmacy,
        ii. dispensation, and
        iii. amount remaining in the pharmacy labeled container(s)
5. The documentation shall be performed simultaneously by:

a. a licensed nurse or staff trained in medication administration leaving duty at the end of each shift, and
b. a licensed nurse or staff trained in medication administration arriving for duty at the beginning of each shift.

6. A system for the prevention or minimization of medication administration errors.
7. Unless contraindicated by an Individual's ISP, procedures for the storage of medication:
    a. in the original labeled prescription container;
    b. in a locked area when stored at room temperature;
    c. in a locked container in the refrigerator if refrigeration is required;
    d. separately from non-medical items; and
    e. under prescribed conditions of temperature, light, humidity, and ventilation.
8. Documentation of an Individual's refusal to take medication.
9. Documentation that the Individual's medical treatments, nursing interventions, and tasks delegated by a qualified licensed medical professional are provided only by trained and authorized personnel.
10. Documentation of medical treatments, nursing interventions or tasks delegated by a qualified licensed medical professional including the following:
    a. Description of the medical treatment, nursing intervention or task delegated by a qualified licensed medical professional.
    b. Date and time of medical treatment, nursing intervention or task delegated by a qualified licensed medical professional.
    c. The initials of the person administering the medical treatment, nursing intervention or task delegated by a qualified licensed medical professional.
11. A system for communication among all Providers that administer:
    a. medication;
    b. medical treatment;
    c. nursing intervention; or
    d. task delegated by a qualified licensed medical professional,
    to an Individual that includes instructions for all Providers working with the Individual to communicate back to the Provider.
12. Providers administering medications, medical treatments, nursing interventions or tasks delegated by a qualified licensed medical professional to the Individual shall:
    a. implement; and
    b. comply with;
    the organized system of medication administration, medical treatments, nursing interventions, and tasks delegated by a qualified licensed medical professional designed by the responsible party.

Individual's Refusal to take Medication

1. If an Individual refuses to take medication, the Provider attempting to administer the medication shall do the following:
    a. Document the following information:
        i. The name of the medication refused by the Individual.

ii. The date, time, and duration of the refusal.
iii. A description of the Provider's response to the refusal.
iv. The signature of the person or persons observing the refusal.

b. Supply the documentation to the responsible party.

2. The party responsible for Health Care Coordination shall ensure a review of the Individual's refusal to take medication with:
   a. the Individual's physician; and
   b. the Individualized Support Team;

   to ensure the health and welfare of the Individual.
3. When an Individual's refusal to take medication presents an immediate danger to the Individual's health and welfare, the party responsible for Health Care Coordination shall initiate reviews prior to the next scheduled administration of the medication that was refused.
4. All Providers administering medication to an Individual shall:
   a. implement; and
   b. comply with;

   documentation of the Individual's refusal to take medication.

Coordination of Medication Side Effects

1. The party responsible for Health Care Coordination shall ensure a system is designed and implemented to monitor side effects an Individual may experience as a result of medication the Individual takes.
2. The party responsible for Health Care Coordination shall ensure the system addressed in subsection (1) is:
   a. personalized based on the needs of the Individual;
   b. documented in writing; and
   c. distributed in writing to all Providers working with the Individual.
3. The system required in subsection (1) shall contain at minimum the following elements:
   a. Training of Direct Support Professional Staff employees, contractors, subcontractors or agents concerning:
      i. the identification of:
         1. side effects; and
         2. interactions;

      of all medication administered to an Individual; and
      ii. instruction on medication side effects and interactions.
   b. A side effect tracking record that includes:
      i. how often the Individual should be monitored for side effects of each medication administered to the Individual;
      ii. who shall perform the monitoring; and
      iii. when monitoring shall be performed.
4. A system for communication among all Providers working with an Individual regarding the monitoring of medication side effects that includes instructions for all Providers working with the Individual to communicate back to the party responsible for Health Care Coordination.

a. All Providers working with an Individual shall:
    i. implement; and
    ii. comply with;

    the medication side effect monitoring system designed by the party responsible for Health Care Coordination.

Coordination of Seizure Management

The party responsible for Health Care Coordination shall ensure a system of seizure management is designed and implemented for an Individual who has a seizure disorder.

1. The party responsible for Health Care Coordination shall ensure the system of seizure management is:
    a. personalized based on the needs of the Individual;
    b. documented in writing; and
    c. distributed in writing to all Providers working with the Individual.
2. The system of seizure management prescribed by subsection (a) shall be developed with input from the Individual's physician or neurologist and include at minimum the following elements:
    a. A description of the type of seizure the Individual experiences.
    b. Actions for staff to take when the Individual has a seizure, as indicated.
    c. Training of Direct Support Professional Staff employees, contractors, subcontractors, or agents concerning the administration of medication.
3. A seizure tracking record for documenting the duration of any seizure, including events:
    a. immediately preceding a seizure;
    b. during a seizure; and
    c. following a seizure.
4. Documentation that seizure records are reviewed at minimum monthly, including referral as necessary for noted issues.
5. Documentation of any necessary physician recommended follow-up and follow along services including but not limited to:
    a. referrals related to a change in:
        i. frequency:
        ii. intensity; and/or
        iii. duration of seizures; and
    b. occurrence of a seizure following a period of:
        i. no seizures; and
        ii. a cluster of seizures.
6. A system for checking the Individual's levels of seizure medication:
    a. at minimum annually; or
    b. as ordered by the Individual's physician.
7. A system for communication among all Providers working with the Individual concerning the Individual's seizures that includes instructions for all Providers working with the Individual to communicate back to the party responsible for Health Care Coordination.
8. All Providers working with the Individual shall:

a. implement; and
b. comply with;

the seizure management system developed by the party responsible for Health Care Coordination.

Coordination of Physical and Nutritional Management Plan

1. The party responsible for Health Care Coordination shall ensure that a written physical and nutritional management plan is developed and implemented for an Individual who has difficulty swallowing.
2. The party responsible for Health Care Coordination shall ensure that the physical and nutritional management plan:
    a. is personalized based on the needs of the Individual;
    b. is committed to writing;
    c. is distributed to all Providers working with the Individual;
    d. is based upon recommendations resulting from:
        i. Speech-Language Pathology oral-motor and swallow studies;
        ii. an Occupational Therapy evaluation defining needs for adaptive equipment;
        iii. an Occupational Therapy or Physical Therapy evaluation defining specific positioning interventions and duration of interventions; and
        iv. a Dietician for nutritional needs.
    e. addresses:
        i. food;
        ii. drink;
        iii. medication administration when physical alteration of medication is indicated;
        iv. saliva management;
        v. emesis management;
        vi. refluxed stomach contents;
        vii. oral care;
        viii. transfers;
        ix. mobility;
        x. positioning for all other activities of daily living, including but not limited to:
            1. bathing;
            2. dressing;
            3. changing.
    f. identifies all special diet, food, fluid, and related texture needs specific to an Individual;
    g. identifies all swallowing difficulties specific to an Individual;
    h. identifies specific risks of aspiration for an Individual;
    i. identifies specific risks of choking for an Individual;
    j. identifies triggers that indicate difficulty in swallowing;
    k. identifies all adaptive equipment specific to an Individual's needs, and instructions for their use;
    l. identifies all positioning needs specific to an Individual;

m. includes instructions for documentation of an Individual's response to the physical and nutritional management plan and of specific triggers that indicate difficulty in swallowing;
n. includes provision for competency based training by the Provider's employees, contractors, subcontractors or agents on the plan prior to working alone with the Individual;
o. contains a system for communication among all Providers working with the Individual concerning the Individual's dysphagia and physical and nutritional management plan that includes instructions for all Providers working with the Individual to communicate back to the Residential Habilitation and Support Provider; and
p. is supported by a physician's order.

3. The party responsible for Health Care Coordination shall ensure ongoing assessment and oversight of:
    a. the Individual's dysphagia symptoms;
    b. the effectiveness of the Individual's specific physical and nutritional management plan in preventing occurrence of dysphagia symptoms; and
    c. the person or persons implementing the Individual's physical and nutritional management plan.
4. All Providers working with the Individual shall:
    a. ensure agents, contractors, subcontractors and employees who provide services to the Individual are trained to competency on the Individual's physical and nutritional management plan;
    b. implement the Individual's physical and nutritional management plan; and
    c. comply with Individual's physical and nutritional management plan, including documentation.

Coordination of Changes in an Individual's Status

1. The party responsible for Health Care Coordination shall maintain personal information for an Individual at the Provider's office. The information shall include documentation of any change in an Individual's physical condition, mental status, or any unusual event, including but not limited to the following:
    a. Vomiting.
    b. Choking.
    c. Falling.
    d. Disorientation or confusion.
    e. Patterns of behavior.
    f. Seizures.
    g. Headaches.
    h. Constipation.
    i. Dehydration.
    j. Weight gain or loss
    k. Change in Sleep pattern.

l. Change in appetite.
m. Change in ability to eat or drink.
n. Change in urine frequency, concentration, odor, amount.
o. Chest pain.
p. Sudden numbness or weakness.
q. Change in breathing pattern.
r. Abnormal bleeding.
s. Change in vision.

2. The documentation of a change or event required by subsection (1) shall include:
    a. dates, times, and duration of the change or event;
    b. a description of the response of the Provider, or the Provider's owners, directors, officers, employees, contractors, subcontractors or agents to the change or event; and
    c. the signatures of the person or persons:
        i. observing the change or event; and
        ii. responding to the change or event.
3. A Provider or Providers working with an Individual shall supply to the party responsible for Health Care Coordination any information regarding any change or event listed in subsection (1) that is observed while the Provider is providing services to the Individuals as follows:
    a. immediately if the change in physical condition or mental status presents an immediate risk to the Individual's health or welfare; or
    b. within twenty-four (24) hours of the change or event if no immediate risk to the Individual.

Coordination of Health-Related Incident Management

1. The party responsible for Health Care Coordination shall design a system of management for BDDS health-related incidents, as described in Incident Reporting Policy, involving an Individual that is:
    a. documented in writing; and
    b. distributed to all Providers working with an Individual.
2. The health-related incident management system prescribed by subsection (1) shall provide an internal review process for any health-related Reportable incident. The Provider's internal review process shall include at minimum the following:
    a. A trend analysis of incidents for an Individual.
    b. Documentation:
        i. that summarizes the findings of the trend analysis; and
        ii. of the steps taken to prevent or minimize the occurrence of incidents in the future.
3. A system for communication among all Providers working with an Individual regarding health-related incidents involving the Individual that includes instructions for all Providers working with the Individual to communicate back to the responsible party.
4. All Providers working with an Individual shall implement the health-related incident management system designed by the responsible party identified.

Coordination of Health Risk

1. When an Individual's health has been identified as being at risk by:
    a. the Individualized Support Team; or
    b. BDDS,

    the party responsible for Health Care Coordination shall ensure a risk plan addressing the health risk issue or health risk issues identified for the Individual is designed and implemented by the Individualized Support Team.
2. At minimum, the following functions, conditions or activities shall be considered when determining risk to an Individual's health:
    a. respiration;
    b. elimination of bowel and bladder;
    c. hydration;
    d. Dysphagia;
    e. seizure;
    f. behavior;
    g. motor function;
    h. skin integrity;
    i. dental health;
    j. nutritional status;
    k. Gastro esophageal reflux disease;
    l. medical diagnosis;
    m. Respiratory conditions;
    n. Endocrine functions;
    o. Neurological functions;
    p. Conditions for which medications are prescribed;
    q. other, as determined by:
        i. the Individualized Support Team; or
        ii. BDDS
3. The Individualized Support Team shall ensure that each risk plan:
    a. is personalized based on the needs of the Individual;
    b. contains essential components to include:
        i. a description of the risk;
        ii. desired outcome of the risk plan;
        iii. baseline data of the risk;
        iv. precursors, if any, to the risk;
        v. proactive preventative supports & strategies to manage the risk;
        vi. reactive supports and strategies to manage the risk;
        vii. documentation requirements; and
        viii. monitoring protocol for the risk plan including:
            1. who reviews risk plan data;
            2. when is risk plan data reviewed;

3. data based criteria for notification of party responsible for Health Care Coordination;
4. identification of party responsible for Health Care Coordination to be notified;
5. process that ensures staff competence with the monitoring protocol.

ix. Quarterly review of the risk plan, at minimum;
x. Strategies for implementation of the risk plan when out of the home;
xi. Training mandates for the risk plan.

c. is included in the Individualized Support Plan; and
d. includes a system for communication among all Providers working with an Individual regarding the management of the health risk, including instructions for all Providers working with the Individual to communicate back to the party responsible for Health Care Coordination.

4. All Providers working with an Individual shall be trained on the risk plan and:
   a. implement; and
   b. comply with the health risk plan.

Coordination of Advanced Directives

1. An Individual's Individualized Support Team shall meet and discuss the Individual's decisions regarding advance directives.
2. The party responsible for Health Care Coordination shall ensure the Individual's decisions for advance directives are documented in the Individual's Individualized Support Plan.

Review of Death

1. If an Individual dies, an internal review into the death shall be conducted by the primary services Provider as determined by DDRS.
2. A Provider conducting a review into the death of an Individual shall:
   a. Notify adult protective services or child protection services, as applicable, upon knowledge of death, but no later than twenty-four (24) hours after the death.
   b. Notify the BDDS representative.
   c. Notify Case manager, if applicable, upon knowledge of death, but no later than twenty-four (24) hours after the death.
   d. Submit an electronic incident report regarding the death.
3. In conjunction with all providers of services to the deceased individual, collect and review documentation of all events, incidents, and occurrences in the Individual's life for at minimum:
   a. the thirty (30) day period immediately before:
      i. the death of the Individual; and
      ii. if applicable, the hospitalization or placement in a hospice setting or nursing facility in which the Individual's death occurred.
4. The internal review into the death of an Individual shall include:
   a. identification of the Individual involved;

b. the date and time of the death;
c. a statement describing the death including in a time-line format:
    i. what happened;
    ii. where it happened;
    iii. when it happened; and
    iv. who was involved.
d. A narrative summary description of the internal review and how it was executed.
e. Identification of all Provider staff assigned to work with the Individual.
f. Identification of all involved parties present at the time of death.
g. Signed and dated statements from Provider staff assigned and present at the time of death.

5. In the case of an unexpected death or when otherwise requested, the party responsible for Health Care Coordination shall also provide a narrative review of the deceased Individual's:
    a. treatment records;
    b. medication administration records;
    c. physician orders;
    d. dietary guidelines;
    e. nutritional assessments;
    f. daily support records;
    g. Individualized support plan;
    h. risk plans;
    i. care plans;
    j. staff notes;
    k. nursing notes;
    l. consultant notes:
    m. progress notes;
    n. training and treatment flow sheets including but not limited to:
        i. bowel tracking;
        ii. seizure log;
        iii. input and output record;
        iv. vital sign records;
        v. risk plans;
    o. consumer specific training;
    p. assigned staff ratios;
    q. hospital & ER admission and discharge summaries; and
    r. all other documentation relevant to the services being provided to the Individual at the time of death.
    s. A narrative summary of a review of relevant Provider policies and procedures.
    t. A narrative summary of the findings of all record and document review associated with the death.
    u. Copies of all documents pertinent to the review of death.
    v. A statement of specific findings from the internal review.
    w. A description of all corrective actions developed as a result of the internal review, including time frames for completion of each corrective action.

x. Documentation of implementation of any corrective actions developed as a result of the internal review.
y. The signature and name and title of the person completing the internal review.
z. The date the internal review was completed.

6. No later than thirty (30) days after the Individual's death, the Provider completing the internal review into the death of an Individual shall send to DDRS per the current DDRS directive:
    a. a completed notice of an Individual's death on a form prescribed by DDRS; and
    b. an internal review into the death of the Individual as described in this section.
    c. A Provider shall respond to any additional requests for information made by BQIS within ten (10) days of the Provider's receipt of a request.

DEFINITIONS

"BDDS" means Bureau of Developmental Disabilities Services as created under IC 12-11-1.1-1.

"Dysphagia" means difficulty in swallowing as a symptom of dysfunction resulting from one or more of the following:

1. a neurological condition;
2. a mechanical/structural condition;
3. a behavioral disorder or condition.

"FSSA" means Indiana Family and Social Services Administration, established per IC 12-8-1-1, which works with Indiana's families, children, senior citizens, people with disabilities and people with mental illness, providing services to promote self-sufficiency, independence, health and safety.

"Health Care Coordination" means coordination services to manage the health care and medical needs of an Individual regardless of the complexity of the health need, including but not limited to:

1. medical consults;
2. medications;
3. development and oversight of risk plans, if indicated;
4. utilization of needed supports; and
5. maintenance of health records.

"Individual" means a person with a developmental disability who has been determined eligible for services by BDDS. If the term is used in the context indicating that the Individual is to receive information or is to provide agreement to some activity, the term also includes the Individual's Legal representative.

"Individualized Support Plan" or "ISP" means a plan that establishes supports and strategies, based upon the Person Centered Planning process, intended to accomplish the Individual's long term and short term outcomes by accommodating the financial and human resources offered to the Individual through paid Provider services, volunteer services, or both, as designed and agreed upon by the Individualized Support Team.

"OMPP" means the Office of Medicaid Policy and Planning as established by IC 12-8-6-1.

"Person-Centered Planning" means a process that:

1. allows an Individual, or the Individual's Legal representative, to direct the planning and allocation of resources to meet the Individual's life goals;
2. achieves understanding of how an Individual:
    a. learns;
    b. makes decisions; and
    c. is and can be productive;
3. discovers what the Individual likes and dislikes; and
4. empowers an Individual and the Individual's Legal representative to create a life plan and corresponding ISP for the Individual that:
    a. is based on the Individual's preferences, dreams, and needs;
    b. encourages and supports the Individual's long term hopes and dreams;
    c. is supported by a short term plan that is based on reasonable costs, given the Individual's support needs;
    d. includes Individual responsibility; and
    e. includes a range of supports, including funded, community, and natural supports.

"Provider" means a person or Entity approved by DDRS to provide an Individual with agreed upon services.

"State Line Item" means a funding source for services authorized by DDRS using 100% state dollars obligated, within available resources, to support Adult individuals who have been determined eligible for developmental disabilities services by the BDDS when all other possible resources, including Medicaid, are unavailable.

REFERENCES

IC 12-9-2-3
IC 12-11-1.1
IC 12-11-2.1
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Approved by: Julia Holloway, DDRS Director